



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX

Division of Medicaid & Children's Health Operations

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San Francisco, CA 94103-6706

MAR 8 2010

Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is the final Financial Management Review report (Control Number 09-FS-2007-CA-01-F) entitled "California's Medicaid Mental Health Care Services Program".

The purpose of our review was to examine the reimbursement process and the use of certified public expenditures (CPEs) to finance "specialty" mental health services delivered through counties in the State of California.

We appreciate your letter of December 14, 2009, in which DHCS generally agreed to CMS' recommendations and requested technical assistance from CMS in developing comprehensive reimbursement and cost-determination methodologies for Medicaid mental health services in California. We have incorporated your response into the enclosed final report, and look forward to assisting California in designing reimbursement methodologies for the mental health services.

Should you or your staff have any questions regarding this matter, please contact Henrietta Sam-Louie at (415) 744-3742 or e-mail her at henrietta.sam-louie@cms.hhs.gov.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Traci Walter, Audit Coordinator



CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Financial Management Review

California's Medicaid Mental Health Care Services Program

**STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES**

Control Number

09-FS-08-CA-05-F

January 2010

**DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
SAN FRANCISCO REGIONAL OFFICE**

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EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) San Francisco Regional Office (RO) performed a financial management review (FMR) of the reimbursement process and the use of certified public expenditures (CPEs) to finance “Medicaid” mental health services delivered through counties in the State of California. In Fiscal Year 2008, expenditures for these services were approximately \$2.8 billion total computable.

Medicaid mental health services in California are provided through 56 individual county, non-risk prepaid inpatient health plans (PIHPs) enabled by a section 1915(b) “freedom of choice” waiver. This review was a continuation of our efforts to understand, document, and evaluate the very complex delivery, payment, and funding of mental health services in California. (In 2007, we performed a review of California’s use of incentive payments for “negotiated rate” providers of Medicaid mental health services and began additional review work on the State’s claims for Medicaid mental health services based on one county.name the county) As part of our review, we met with the Department of Health Care Services (the State Medicaid Agency), the State Department of Mental Health, and representatives from five counties (list the counties) that provide and claim for Medicaid mental health services.

Findings

1. California’s cost-reimbursement methodologies for mental health services that are claimed using CPEs are not approved by CMS, are not consistent with CMS policy, and may result in inaccurate expenditures used as the basis for the county CPEs.
2. Our review found inconsistencies and weaknesses in the county and State oversight and auditing of the cost report process.
3. The State is improperly claiming for administrative expenditures associated with Medicaid mental health services provided by counties and funded through CPEs.
4. The California Medicaid State plan contains outdated reimbursement methodologies and terminology for mental health services.
5. The State does not calculate the non-risk upper payment limit (UPL) applicable to non-risk PIHPs for the services provided under the mental health plan (MHP) contracts to demonstrate compliance with 42 CFR 447.362 and cannot do so because the State plan reimbursement sections are outdated.

Recommendations

1. The State must amend its State plan to comprehensively describe the State’s reimbursement and cost-determination methodologies for mental health services. (This recommendation should reference the fact that the State had submitted CA 09-004 (see recommendations b and c on page # 8))

2. The State must submit for CMS approval, a document which articulates the procedures and methodologies the State will use to determine those MHP PIHP costs eligible for federal matching through CPEs.
3. The CMS 2552-96 Medicare cost report should be required in support of all county CPEs for hospital services.
4. The State should modify its cost report for non-hospital services to address our review observations and submit this state-developed cost report to CMS for review and approval.
5. The CMS 64.10 administrative costs as incurred by the counties should be evaluated separately to ensure compliance with CMS administrative cost claiming policy. The State must exclude improper county claims for administration from claims for FFP on the CMS-64 reports.
6. The State should increase its training to the MHPs and oversight of the cost-reports submitted by the 56 MHPs to ensure consistency and accuracy.
7. The State must begin calculating the annual, non-risk UPL required for non-risk PIHPs for each MHP, beginning with the SFY ending June 30, 2010.

STATE RESPONSE

The State generally agreed to our recommendations and requested technical assistance from CMS in developing comprehensive reimbursement and cost-determination methodologies for Medicaid mental health services in California. A copy of the State's response is included at the end of this report.

I. INTRODUCTION / BACKGROUND

California Medi-Cal Medicaid Mental Health Services

In California, most Medicaid (known as “Medi-Cal”) mental health services are the responsibility of 56 individual counties and are referred to as “Medicaid mental health services (SMHS).” Beginning in 1995, and with CMS approval of the Specialty Mental Health Services Consolidation (SMHSC) section 1915(b) waiver, the State began shifting the responsibility for the provision and financing of both inpatient and outpatient Medicaid mental health services to the counties.

The California Department of Health Care Services (DHCS) entered into agreement with the California Department of Mental Health (DMH) for the administration and oversight of SMHS. DMH contracts with individual counties, each of which operates as a “county mental health plan (MHP)” and provides SMHS:

- directly (through county-owned and -operated hospitals, clinics, and individual providers);
- through contracts with private “organizational providers¹,” including clinics;
- through contracts with individual private providers (“Program II”); and
- through private hospitals.

Each county MHP acts as a managed care plan (a non-risk prepaid inpatient health plan) and is responsible for maintaining a provider network, authorizing services, determining provider payment rates, and paying most providers. Providers in the first three groups described above bill on a fee-for-services basis and are paid directly by each county MHP. These providers are referred to as “Short-Doyle/Medi-Cal (SD/MC)” providers.

The remaining SMH services providers are private hospitals referred to as “Fee-For-Service/Medi-Cal (FFS/MC)” inpatient hospital providers². These hospitals are also reimbursed for inpatient hospital services on a fee-for-service basis, but are paid directly by the State Medicaid agency for only those services that have been approved by the MHP (excluding emergency services).

In Fiscal Year 2008, total computable expenditures for Medi-Cal Medicaid mental health services were approximately \$2.8 billion.

¹ “Organizational Providers” are defined in §1810.231 of Title 9 in California state law as “a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waived/registered professionals and other staff.”

² While most private hospital providers of SMHS participate as FFS/MC providers, there are a small number of private hospitals that have chosen to contract with counties as SD/MC providers.

Funding for Medicaid Mental Health Services

SD/MC Funding

The source of the non-federal share for services provided by SD/MC providers is certified public expenditures (CPEs) from each county. Annually, each county submits a single cost report to the State DMH that is an aggregate cost report comprised of data submitted on individual cost reports from “legal entities” (county hospitals and non-institutional private clinic and organizational providers that are required to submit their own cost reports) as well as the county’s own expenditures for providing or contracting for services (costs of county non-institutional providers and payments to private individual providers.)

FFS/MC Funding

The source of the non-federal share for services provided by FFS/MC providers is state general funds from DHCS, which is repaid by DMH out of funding allocated to DMH for the county MHPs. Thus, county MHPs are also financially responsible for the FFS/MC expenditures. (However, unlike for SD/MC, the non-federal share funding is not CPEs by MHPs.)

SMH Services--Claims Processing and Payment

SD/MC Providers

County MHPs submit claims to DMH for processing and are forwarded to DHCS for payment. A county MHP submits a form certifying that it incurred the expenditures associated with the submitted claims. DMH compares the claimed amount to a schedule called the “State Maximum Allowance (SMA)” and will approve the lower of what is billed or the SMA.

DMH submits the batch of edited claims to DHCS for further processing. DHCS processes the claims to determine whether the services provided meet Federal and state program requirements.³ DHCS determines whether the claims are approved, denied, or suspended.⁴ Once this is determined, it electronically returns the entire batch of claims to DMH with a determination of how much FFP is due the county MHPs. DHCS then submits an invoice to the State Controller for FFP. Once FFP is received by DHCS, it passes the federal funds through DMH back to the MHPs.

FFS/MC Inpatient Hospital Providers

FFS/MC hospitals are reimbursed based on contracted rates determined by the county MHP (or determined by the State, if non-contracted). These rates include reimbursement for routine hospital ancillary services, but exclude the physician services which are billed through the SD/MC process.

³ For example, DHCS edits for Medi-Cal eligibility.

⁴ The denied and suspended claims are those that DHCS found to not meet program requirements or are unallowable for other reasons. The MHP’s may resubmit those claims that can be amended to be approvable.

SD/MC Cost Reporting and Settlement Process

The California State plan does not contain a description of the methodology for determining costs. DMH issues annual guidance (in the form of DMH Notices and Letters) on the cost report process and conducts trainings at the county level on how the cost report should be completed. Each MHP is required to submit a state-developed cost report to DMH by December 31st following the close of the fiscal year. The cost report package includes:

- An aggregate cost report for the MHP, including the MHP's own costs of providing services through county-owned providers (excluding hospitals), as well as the MHP's cost of reimbursing private non-hospital providers that do not submit their own cost reports ("Program II" providers);
- Individual cost reports for all other providers, including county hospitals and organizational providers designated as "legal entities." All legal entities are required to file the state-developed cost report with the MHP, and these individual cost reports are included in the cost report package.

The cost report serves to: (1) compute the cost per unit for each service function; (2) determine the lowest of cost, published charges, or SMA for each service function; (3) determine the net allowable FFP for each legal entity; and (4) function as the basis for the year-end cost settlement and fiscal audit. The cost report is settled at the lower of cost, published charges, or SMA at the legal entity level.

There are two types of cost settlements – the interim settlement and the final settlement. The interim settlement occurs 12 months after the counties submit the year-end cost reports to the DMH. The final cost settlement occurs approximately 3 to 5 years following the submission of the county cost reports. It is during final settlement that the DMH performs compliance audits of the county cost reports. At final settlement overpayment may also be identified.

II. PURPOSE, SCOPE AND METHODOLOGY

The purpose of the review was to:

1. Further document California's reimbursement process and the certified public expenditures used to finance the Medicaid payments to the MHPs for SD/MC SMHS and determine whether California's CPE process meets CMS current requirements for interim payments, reconciliations, and cost-settlements for CPE-related expenditures;
2. Document California's reimbursement process for FFS/MC SMHS and determine whether that process meets CMS requirements; and
3. Determine whether California is calculating and demonstrating compliance with the non-risk UPL rules found at 42 CFR 447.362 that apply to non-risk PIHPs.

Our review was conducted in September and October of 2008, at the State's offices in Sacramento, California and on-site at five county MHPs. To accomplish our objectives we:

- Reviewed applicable State and federal laws and regulations, the State plan, the Section 1915(b) Specialty Mental Health Services Consolidation Waiver, and the contracts between DMH and the county MHPs;
- Reviewed DMH documents, including program instructions, claims processing and cost reporting procedures;
- Interviewed DHCS, DMH, and staff from five county MHPs;
- Reviewed county MHP documents, including program instructions and cost reporting procedures; and
- Reviewed the most recent audited cost reports (SFY 2002-03) from each of the five county MHPs, including a limited number of institutional and non-institutional "legal entities" for each of the five MHPs.

III. FINDINGS AND RECOMMENDATIONS

1. California's cost-reimbursement methodologies for its SD/MC mental health services that are claimed using CPEs are not approved by CMS and are not consistent with CMS policy.

California uses a State-developed cost reporting tool that has not been approved by CMS to determine Medicaid mental health costs. This may result in inaccurate expenditures used as the basis for the county CPEs. Cost reimbursement methodologies must be approved by CMS to ensure that allowable Medicaid costs are identified and reported to support a certified public expenditure. As part of the cost identification process, a state must furnish to CMS, for review and approval, a cost report (with instruction) that determines the total Medicaid costs incurred by the provider. For hospital services, CMS requires states to use the Medicare hospital cost reporting form CMS-2552-96, which is a national cost report. For non-hospital services, states have been permitted to develop a state-specific report to capture Medicaid service costs, subject to CMS review and approval.

California uses a state-developed cost report as the basis for its CPEs for mental health hospital services, not the CMS-2552-96 Medicare cost report. The State also uses the same state-developed cost report as the basis for CPEs for non-hospital services, but this report has not been approved. Examples of where the state-developed cost report deviates from what is approvable under CMS policy:

- The state-developed cost report filed by non-county legal entity providers computes the Medicaid reimbursable amount based on those providers' costs, which under certain circumstances may be greater than the county's actual cost incurred. Given that these mental health expenditures claimed for FFP are funded by the county's CPEs, the county's actual cost incurred should always be a component of the cost reporting process (and not merely as a post-cost report audit recovery item), even in cases where a non-county mental health legal entity is the provider of service.
- There is no assurance that the mental health costs, as determined by the state-developed cost report, adequately account for any necessary adjustment for costs that would be unallowable under Medicaid reimbursement policies.
- The state-developed cost report also reports the administrative costs claimed as CMS-64.10 administrative expenditures. There is no assurance that the administrative costs as determined through this cost reporting process are in compliance with CMS administrative cost policies including those contained in OMB A-87.

Recommendations:

- (a) The State must submit for CMS approval, a document which articulates the procedures and methodologies it will use to determine those MHP PIHP costs eligible for federal matching through CPEs.** The State should submit this as an amendment to its section 1915(b) Specialty Mental Health Consolidation Waiver by June 30, 2010.
- (b) The CMS 2552-96 Medicare cost report should be required in support of all County MHP CPEs for hospital services.** The State should revise its instructions to the County MHPs and submit this cost report to CMS for review and approval as an amendment to the State's §1915(b) Specialty Mental Health Services Waiver. The State should implement this recommendation concurrently with the updates it is requesting in the State plan under pending CA SPA #09-004 for coverage and reimbursement of mental health services that was submitted, in part, to address CMS' findings in our FMR report #09-CA-02-2006-06.
- (c) The State should modify its cost report for non-hospital services to address our review observations and submit this state-developed cost report to CMS for review and approval as an amendment to the §1915(b) Specialty Mental Health Services Waiver.** The State should implement this recommendation concurrently with the updates it is requesting in the State plan under pending CA SPA #09-004 for coverage and reimbursement of mental health services that was submitted, in part, to address CMS' findings in our FMR report #09-CA-02-2006-06.

THE STATE'S COMMENTS:

The State agreed to our recommendation to submit to CMS for review and approval the state-developed cost report and a document that will articulate the cost determination methodology and address the review recommendations. The State also agreed to amend its Section 1915(b) waiver. However, the State requested to use one cost report for both hospital and non-hospital service costs rather than separate cost reports.

The State also provided additional information to clarify their existing cost reporting process. A copy of the State's response is included at the end of this report.

CMS COMMENTS:

CMS will consider the State's request to utilize a single cost report provided the hospital costs are apportioned using the Medicare 2552 cost apportionment method. However, the State must continue to be able to differentiate between

inpatient hospital costs, outpatient hospital costs, and other costs within its cost report.

Despite the State's additional information regarding its existing cost reporting process, CMS continues to believe that there is a need to incorporate additional cost reporting and/or audit and settlement procedures to ensure that our observations (e.g., CPE claims based on the non-county legal entity costs) are adequately addressed.

2. Inconsistencies and weaknesses in county MHP and State oversight and auditing of the cost report process.

Examples include:

- The counties' review of provider cost reports varies by county. The State's cost report settlement process, which occurs within one year of cost report filing, does not review any cost elements from the cost reports but focuses on only reconciling service units. It is not until the State's final audit that cost elements are subject to any level of State review. The State final audit does not occur until at least three years after the cost reports are filed to the State. Even then, the State's audit sampling of non-county provider cost reports appears to be very limited.
- The time lag in performing the State final audit is of particular concern given that the cost report settlement process prior to the final state audit does not account for instances where a county's CPE may be based on legal entity provider costs instead of actual costs/expenditures incurred by the county.

Recommendation:

The State should increase its training to the MHPs and oversight of the cost-reports submitted by the 56 MHPs to ensure consistency and accuracy. The State should submit a new training and oversight plan to CMS no later than three months after finalization of the revised cost reports.

THE STATE'S COMMENTS:

The State agreed to our recommendation and will submit a new training and oversight plan within three months after finalization of the revised cost report. The State also provided additional information to outline the steps from the initial cost report submission to the cost report audit. A copy of the State's response is included at the end of this report.

The State also clarified that published charges are not used in determining the reimbursable amount of certain contracted services ("Program II").

CMS COMMENTS:

We appreciate the State's additional description of the cost report settlement timeline. The State should fully define the audit and settlement process, including all audit and settlement timelines, in the revised cost report protocol that will be submitted to CMS.

Based on the State's clarification on the use of published charges for "Program II" services, we have deleted this example in our findings in the final report.

3. The State is improperly claiming for administrative expenditures associated with Medicaid mental health services provided by counties and funded through CPEs.

- The State's claim for administrative expenditures is partially based on estimates. Some counties are certifying an interim estimate of administrative expenditures, not actual administrative costs, as required.
- The State is also claiming for a small amount of county administrative costs as medical service costs. Counties that were claiming administrative costs as medical assistance costs were doing so when the county subcontracted to an administrative service organization (ASO) to provide Medicaid mental health services for children in foster care. These ASOs reimburse providers of services on behalf of the county and also receive a monthly per-member/per-month (PMPM) administrative payment for this function. The monthly PMPM payment from the county to the ASO was being claimed as a medical service. This occurred in three of the five counties reviewed.

By using an interim estimate to claim administrative costs and by claiming ASO administrative costs as medical expenditures, the State is also not calculating an accurate administrative cost amount applicable to the two-year waiver cycle and related "cost-effectiveness" test for the Section 1915(b) waiver.

Recommendation:

The CMS 64.10 administrative costs as incurred by the counties should be evaluated separately to ensure compliance with CMS administrative cost claiming policy. The State should issue revised instructions to the counties on administrative claiming to specify that:

- a) County CPEs and claims must be based on actual costs, not estimates, and,
- b) ASO administrative expenditures should not be reported as medical service expenditures.

The State must exclude improper county claims from claims for FFP on the CMS-64 reports. The State must correct these deficiencies by the June 30, 2010 quarterly expenditure report. Failure to timely address these issues will put FFP at risk.

THE STATE'S COMMENTS:

The State agreed with our recommendation. A copy of the State's response is included at the end of this report.

4. The California Medicaid State plan contains outdated reimbursement methodologies and terminology for mental health services.

For example:

- The State does not apply the reimbursement limits to “legal entities” as these entities are defined in the state plan; the state plan’s definition is more expansive than the current definition applied by the State⁵ because it includes individual providers (“Program II”).
- The State plan on page 43 of Attachment 4.19A specifies that “these provisions will be in effect from January 1, 1995, until such time as the State’s pending and related 1915(b) waiver is approved.” Thus, the provisions for contracted FFS/MC inpatient hospital services appear to be moot since the approval of the SMHSC section 1915(b) waiver.

The State plan for mental health services, including those provided by both SD/MC providers and FFS/MC inpatient hospital providers, is not current and does not reflect current State payment policies and State laws for fee-for-service arrangements. California has not updated the reimbursement sections of its State plan for most mental health services since it implemented its Section 1915(b) waiver program in the mid-1990’s. With the approval of California’s 1915(b) SMHSC waiver, it is CMS’ understanding that CA incorrectly believed that the reimbursement rules governing mental health services were governed only by the waiver.

Recommendation:

The State must amend its State plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and describe the providers of service (e.g., hospitals, county MHPs).

⁵ The State plan includes individual providers (“Program II”) but the documentation we received from DMH during our review specified that “legal entities” exclude individual/group providers, FFS/MC hospitals, and psychiatric nursing facilities.

We recognize that the State has begun this work through the submission of pending SPA #09-004.

THE STATE'S COMMENTS:

The State agreed to our recommendation and requested technical assistance from CMS on the development of appropriate reimbursement and cost-determination methodologies, upper payment limits, and provider categories. A copy of the State's response is included at the end of this report.

The State also provided new information to CMS on the use of "psychiatric accommodation codes" by the FFS/MC hospitals to bill for services and confirmed that these codes are still being used.

CMS COMMENTS:

CMS is available to provide any technical assistance needed and we will continue to work closely with the State on pending SPA #09-004 as well as the State's section 1915(b) waiver.

Based on the new information provided about the use of "psychiatric accommodation codes," we have deleted this example in our findings in the final report.

- 5. The State does not calculate a non-risk UPL for services provided under the MHP contracts to demonstrate compliance with 42 CFR 447.362 and cannot do so because the state plan reimbursement sections are outdated and may not reflect current State law and policies.**

When a state contracts with non-risk PIHPs for services, it must have a current, approved reimbursement methodology in its State plan for those services in order to calculate "what Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to recipients" under the non-risk UPL rules.

Recommendations:

- (a) The State must amend its State plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and describe the providers of service (e.g., hospitals, county MHPs).**
We recognize that the State has begun this work through the submission of pending SPA #09-004.
- (b) The State must begin calculating the annual, non-risk UPL for each MHP, beginning with the SFY ending June 30, 2010.**

THE STATE'S COMMENTS:

The State agreed to our recommendation to revise its State Plan but, as noted in the response to Recommendation #4, requested technical assistance from CMS on the development of appropriate reimbursement and cost-determination methodologies, upper payment limits, and provider categories. A copy of the State's response is included at the end of this report.

CMS COMMENTS:

CMS is available to provide any technical assistance needed and we will continue to work closely with the State on pending SPA #09-004 as well as the State's section 1915(b) waiver and the development of the non-risk UPL calculation.



DAVID MAXWELL JOLLY
Director

State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

DEC 14 2009

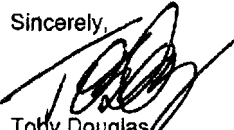
Ms. Gloria Nagle
Associate Regional Administrator
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90 Seventh Street, Suite 5-300 (5W)
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Dear Ms. Nagle:

The California Department of Health Care Services (DHCS) has prepared its response to the Centers for Medicare & Medicaid Services (CMS) draft report entitled "California's Specialty Mental Health Care Services Program" (Control Number 09-FS-08-CA-05-D). DHCS appreciates the work performed by CMS and the opportunity to respond to the draft report.

Please contact Ms. Barbara Bailey, Chief, Medi-Cal Benefits, Waiver Analysis, and Rates Division at (916) 552-9400 if you have any questions.

Sincerely,



Toby Douglas
Chief Deputy Director
Health Care Programs

cc: See next page

Ms. Lori A. Ahlstrand
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cc: Ms. Vanessa Baird
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**Department of Health Care Services' Response to the
Centers for Medicare & Medicaid Services' Draft Report Entitled**

California's Specialty Mental Health Care Services Program

Finding

California's cost-reimbursement methodologies for its SD/MC mental health services that are claimed using CPEs are not approved by CMS and are not consistent with CMS policy.

Recommendation: The State must submit for CMS approval, a document which articulates the procedures and methodologies it will use to determine those MHP PIHP costs eligible for federal matching through CPEs. The State should submit this as an amendment to its section 1915(b) Specialty Mental Health Consolidation Waiver by June 30, 2010.

Response: The Specialty Mental Health Services Consolidation Waiver was first implemented in 1995. Since the inception of the waiver program, county Mental Health Plans have been using a state-developed cost report.

According to the Centers for Medicare and Medicaid Services' (CMS) new policy that state-developed cost reports be submitted to CMS for their review and approval, the State will submit to CMS for review and approval the state-developed cost report and a document that will articulate the procedures and methodologies that will be used to determine those Mental Health Plan (MHP) prepaid inpatient health plan (PIHP) costs eligible for federal financial participation (FFP) through certified public expenditures (CPEs). The State will submit this as an amendment to its section 1915(b) Specialty Mental Health Consolidation Waiver by June 30, 2010. The state-developed cost report, procedures and methodologies will specify that at initial cost settlement, Mental Health Plans cannot be reimbursed FFP for non-county legal entity costs in excess of the county's total payments to the non-county legal entity, irrespective of the non-county legal entity's total costs that exceeded the county's total payments.

The State offers the following information regarding its current procedures and methodologies relevant to the examples listed in the draft report. With respect to the first bulleted example, the state-developed cost report is submitted and certified by the county. The county Auditor Controller signs the cost report to certify, among other things, that the cost report is "based on actual total expenditures as necessary for claiming FFP pursuant to State and Federal requirements including, but not limited to Sections 430.30 and 433.51

of Title 42 of the Code of Federal Regulations (CFR)." The county Auditor Controller certifies that the costs contained in the cost report, including those for non-county legal entity providers, meet requirements for CPEs pursuant to State and Federal regulations, such as Section 433.51 of the CFR. Since Federal regulations require CPEs to be based upon actual expenditures of the county, the county Auditor Controller is certifying that the cost report is based upon actual expenditures of the county and does not include expenditures that the county did not incur.

The state-developed cost report procedures also include a review process, which compares total county payments made to each non-county legal entity provider to adjusted gross costs reported on the non-county legal entity cost report. If the county reports that it paid the non-county legal entity provider an amount that is different from the adjusted gross costs reported on the non-county legal entity cost report, staff request that the county explain why the amount paid is different from the costs reported. The explanation is included with the county's cost report.

Concerning the second bulleted example, the cost report includes a form (MH 1961) that allows all legal entities to adjust their gross costs to Medicaid principles. The State's instructions specify that legal entities are expected to use this form to adjust costs for Medi-Cal and Medicare principles of allowable costs. The State's instruction manual also directs legal entities to CMS Publication 15 for further explanation of Medi-Cal allowable and non-allowable costs. The county certifies the cost report, which is the State's assurance that the adjustments were made in accordance with State and Federal regulations. The State verifies the adjustments during the final audit.

Concerning the third bulleted example, current State policy provides guidance to counties on computing the administrative costs submitted for reimbursement under the Medi-Cal program, which direct counties to comply with Medicaid reimbursement policies. The State's policy is described in Department of Mental Health (DMH) Letter 05-10, which specifically states that the administrative costs must be determined through an acceptable allocation method as described in CMS Publication 15-1. DMH Letter 05-10 also states that approved OMB A-87 costs are allowable, but overhead costs that are not part of the county's approved OMB A-87 plan are not allowable.

Recommendation: The CMS 2552-96 Medicare cost report should be required in support of all County MHP CPEs for hospital services. The State should revise its instructions to the County MHPs and submit this cost report to CMS for review and approval as an amendment to the State's §1915(b)

Specialty Mental Health Services Waiver. The State should implement this recommendation concurrently with the updates it is requesting in the State plan under pending CA SPA #09-004 for coverage and reimbursement of mental health services that was submitted, in part, to address CMS's findings in our FMR report #09-CA-02-2006-06.

Response:

Legal entities that provide psychiatric inpatient hospital services currently complete the CMS 2552-96 and submit that report to the Department of Health Care Services (DHCS). State auditors use the CMS 2552-96 submitted to the DHCS and supporting documentation to reconcile the costs allocated to psychiatric inpatient hospital services on the state-developed cost report.

The State will work with counties and their legal entity providers to develop a process to include the CMS 2552-96 and supporting documentation as part of the state-developed cost reporting package. The State will revise its procedures and methodologies to reconcile the costs reported on the state-developed cost report for psychiatric inpatient hospital services with those reported on the CMS 2552-96 and supporting documentation submitted with the state-developed cost reporting package.

The State would like to use one cost report to settle FFP for inpatient and outpatient services' costs. It seems reasonable that inpatient costs reported in the state-developed cost report can be reconciled with the CMS 2552-96 and that the CMS 2552-96 is submitted as part of the cost reporting package.

The State currently uses one cost report to complete interim settlement of FFP for inpatient and outpatient costs. The state-developed cost report calculates one total amount of FFP due to a MHP based upon the inpatient and outpatient costs reported on its cost report. The FFP amount is then compared to the total amount of FFP that has already been paid to the MHP based on claims that the MHP has submitted for inpatient and outpatient services provided. The data used for the calculation is contained in the automated set of forms of the state-developed cost report.

The implementation of the above recommendation would require legal entities to report their inpatient costs on the CMS 2552-96 and report their outpatient costs on a CMS approved state-developed cost report. The State would need to redesign its processes to include an interim settlement for outpatient services using the CMS approved state-developed cost report, and for each legal entity that provided psychiatric inpatient services using the CMS 2552-96.

In addition, the State would be required to compare total FFP due to the MHP for outpatient services with the total payments made to the MHP for outpatient services, and total FFP due to the MHP for inpatient services provided by each legal entity with total payments made to the MHP for inpatient services provided by the each legal entity, instead of comparing total FFP due to the MHP with total payments made to the MHP. Also, it would require the State to prepare claims paid data with much more detail, and the State to perform multiple interim settlements for outpatient and inpatient services.

Furthermore, the State would need to determine that the CMS 2552-96 and CMS approved state-developed cost report are consistent in applying the lower of cost, published charges or State Maximum Allowance (SMA) principle to inpatient hospital services.

Recommendation: The State should modify its cost report for non-hospital services to address our review observations and submit this state-developed cost report to CMS for review and approval as an amendment to the §1915(b) Specialty Mental Health Services Waiver. The State should implement this recommendation concurrently with the updates it is requesting in the State plan under pending CA SPA #09-004 for coverage and reimbursement of mental health services that was submitted, in part, to address CMS' findings in our FMR report #09-CA-02-2006-06.

Response: The State will modify its cost report forms and processes to address the review observations in the Financial Management Review (Control # 09-FS-08-CA-05-D). These modifications will specifically address the following review observations to include:

- a mechanism to verify that non-county legal entity cost reports only include costs that were paid by the Mental Health Plan.
- assurances that the gross costs for medical assistance do not include costs that are not allowed under Medicaid reimbursement policies, such as the CMS-15.
- assurances that the administrative costs included in the cost report are in compliance with CMS administrative cost policies, including those contained in OMB A-87.

The State will submit this modified cost report to CMS for review and approval as an amendment to the Section 1915(b) Specialty Mental Health Services Waiver. The State will implement these modified cost report forms and processes concurrently with the updates it is requesting in the State plan under pending CA SPA #09-004.

Finding

Inconsistencies and weaknesses in county MHP and State oversight and auditing of the cost report process.

Recommendation: The State should increase its training to the MHPs and oversight of the cost reports submitted by the 56 MHPs to ensure consistency and accuracy. The State should submit a new training and oversight plan to CMS no later than three months after finalization of the revised cost reports.

Response: The State will submit to CMS a new training and oversight plan no later than three months after finalization of the revised cost report.

The State offers a significant amount of training and ongoing technical assistance to counties in regards to the cost report process. Typically, the State offers annual training to all MHPs in June, July, or August prior to the cost report submission in December. However, due to modifications to the cost report forms required to implement findings in FMR report #09-CA-02-2006-06, cost report training did not occur until November for the Fiscal Year 2008-09 cost report process.

In addition to annual training, the State employs six staff who are available to provide one-on-one technical assistance and training to counties that have questions regarding the completion of cost reports. For example, each MHP uploads its cost report via the Department of Mental Health's Information Technology Web Services (ITWS) and soon thereafter receives an automated error report which indicates that items may not be correct within the cost report. State staff members assist MHPs with resolving these errors prior to the initial cost report submission.

The State will update its training and automated error reports to incorporate modifications made to the cost report pursuant to previous recommendations and submit a training and oversight plan to CMS. The new training and oversight plan will specify that the Mental Health Plan cannot be reimbursed FFP at initial cost settlement for non-county legal entity costs in excess of the county's total payment to the non-county legal entity, irrespective of the non-county legal entity's actual costs that may have exceeded the county's payment.

There is additional information in regards to the cost report preparation and submission as it pertains to the examples listed in the draft report. The first bulleted example states that county cost reporting did not consistently follow State instructions for reporting published charges for "Program II" providers' units of service. The State does not require

published charges to be reported for "Program II" providers, instead the instruction manual specifies that Program II contracted services are settled at the lower of actual cost or SMA (FY 2007-08, CFRS-69). Counties are appropriately following the cost report instructions by not reporting a published charge for Program II providers.

With respect to the third bulleted example, the State would like to outline the steps from initial cost report submission to the cost report audit. Counties must submit a complete cost report by December 31st following the close of the fiscal year. Approximately six to nine months later, counties receive their cost report and a letter from the State explaining the reconciliation process. During this time, the county may shift units of service from Medi-Cal to non-Medi-Cal units of service and change patient and other payer revenues. Counties must upload their final reconciled cost report within 30 days of receiving the letter from the State. Counties must submit a hard copy of the final cost report within 10 days of uploading the cost, with a signed and dated certification. Again, the county Auditor Controller certifies that the costs contained in the cost report, including those for non-county legal entity providers, meet requirements for CPEs pursuant to State and Federal regulations. The State is responsible for auditing the cost report within three years of the date of the final cost report certification.

Finding

The State is improperly claiming for administrative expenditures associated with specialty mental health services provided by counties and funded through CPEs.

Recommendation: The CMS 64.10 administrative costs as incurred by the counties should be evaluated separately to ensure compliance with CMS administrative costs claiming policy. The State should issue revised instructions to the counties on administrative claiming to specify that:

- County CPEs and claims must be based on actual costs, not estimates, and
- ASO administrative expenditures should not be reported as medical service expenditures.

Response: The State will evaluate the CMS 64.10 report to ensure compliance with CMS administrative cost claiming policy, and exclude any improper county claims for FFP on the CMS 64 reports. The State will correct any identified deficiencies by the June 30, 2010 quarterly expenditure report.

The State will issue revised instruction to counties on administrative claiming to specify that County CPEs and claims must be based on

actual costs, and not estimates. The State will also clarify in its cost report instructions that costs associated with units reported under the administrative service organization (ASO) cost settlement type should only include expenditures for medical services and should not include any payments made to the ASO for the purpose of coordinating payments between the county of beneficiary and the host county. ASO expenditures should not be reported as medical assistance expenditures.

Finding

The California Medicaid State plan contains outdated reimbursement methodologies and terminology for mental health services.

Recommendation: The State must amend its State plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and describe the providers of service (e.g., hospitals, county MHPs). We recognize that the State has begun this work through the submission of pending SPA #09-004.

Response: The State will amend its State Plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and describe the actual providers of service (e.g. hospitals, counties, other non-state governmental entities, and other private operated facilities, etc.). As CMS notes, the State has already begun this work through submission of pending SPA #09-004. The State is continuing to work with CMS on appropriate language for pending SPA #09-004. In completing this SPA, the State requests technical assistance from CMS concerning whether there are particular federal statutes or regulations – such as Parts within Title 42, Code of Federal Regulations (CFR) – which the State should review in order to develop appropriate reimbursement and cost-determination methodologies and provider categories for California's specialty mental health services in the State Plan that meet CMS requirements.

The State may also consider CMS's suggestion to complete SPA #09-004 to specify that the various categories of providers who render specialty mental health services be paid up to actual (e.g. "*fair and reasonable*") cost according to appropriate federal guidelines. If the State were to pursue this option, further limitations in payments for some/all targeted groups of specialty mental health services providers – such as paying no more than a State Maximum Allowance (SMA), published or customary charges, or contracted amounts – may be established in the Medi-Cal Specialty Mental Health Services (SMHS) waiver or associated authorities. In this way, actual SMHS waiver costs would not exceed the calculated non-risk PIHP upper payment

limit (UPL) for any county MHP. However, in order for the State to make a determination on this, as well as on other issues, the State would like a fuller understanding of the specific federal statutory/regulatory authorities related to: (1) the categories of providers that must be established and/or the State's flexibility in establishing provider categories; and (2) the specific federal statutory/regulatory guidelines for establishing appropriate reimbursement and cost determination methodologies.

As described in CMS's Recommendation 1. (c) on Page 7, the language the State includes in the SPA for reimbursement, cost-determination and to describe categories of providers (e.g., hospitals, county MHPs) will be consistent with the State's modification of the cost report for non-hospital services and will be appropriately reflected in the Medi-Cal SMHS waiver amendment. Per Recommendation 2. on Page 8, the State will also include any changes in reimbursement and cost-determination methodologies and provider categories in county MHP training materials.

Concerning CMS's bullet Number One under Finding #4, Page 9 of draft FMR 09-FS-08-CA-05-D, the State will appropriately revise the definition of "legal entities" in SPA #09-004 to reflect current State payment policies and State laws which now include individual Medi-Cal providers (e.g. "Program II"). Concerning CMS's bullets Two and Three on Page 9 of the FMR, the State notes that CMS is here referring to the State's reimbursement methodology for Fee-for-Service Medi-Cal (FFS/MC) psychiatric inpatient hospital providers, as described in the State plan in Attachment 4.19-A, Pages 41 through 45. The State acknowledges that some changes to this State Plan Attachment 4.19-A, Pages 41 through 45, "REIMBURSEMENT FOR FEE-FOR-SERVICE MEDI-CAL PSYCHIATRIC INPATIENT HOSPITAL SERVICES", may be necessary as part of SPA #09-004. However, FFS/MC psychiatric inpatient hospital providers still bill through the State's fiscal intermediary, Electronic Data Systems, Inc. (EDS) on a per diem basis and still use "psychiatric accommodation codes" as referenced on pages 42 and 43 of Attachment 4.19A. Though the State Plan on page 43 of Attachment 4.19A specifies that *"these provisions will be in effect from January 1, 1995, until such time as the State's pending and related 1915(b) waiver is approved"*; the State currently utilizes many/most of these provisions since the State has never appropriately updated Attachment 4.19A, Pages 41 through 45, of the State Plan since approval of SPA #95-016, (effective January 1, 1995), on May 16, 1997. The State will thus update this section of the State Plan as appropriate. However, FFS/MC psychiatric inpatient hospitals still do bill EDS for approved per diem rates based on psychiatric accommodation codes.

Finding

The State does not calculate the non-risk upper payment limit (UPL) for services provided under the MHP contracts to demonstrate compliance with 42 CFR 447.362 and cannot do so because the State plan reimbursement sections are outdated and may not reflect current State law and policies.

Recommendation: The State must amend its State plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and describe the providers of service (e.g., hospitals, county MHPs). We recognize that the State has begun this work through the submission of pending SPA #09-004.

Response: Per the State's response to CMS's Recommendation, Finding #4, directly above, the State will amend its State Plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and the actual providers of service (e.g. hospitals, counties, other non-state governmental entities, and other private operated facilities, etc.). As CMS notes, the State has already begun this work through submission of pending SPA #09-004. In completing SPA #09-004, the State requests technical assistance from CMS concerning particular federal statutes or regulations – such as Parts within Title 42, Code of Federal Regulations (CFR) – which the State should review and incorporate to develop appropriate reimbursement and cost-determination methodologies and provider categories for California's specialty mental health services in the State plan.

Recommendation: The State must begin calculating the annual, non-risk UPL for each MHP, beginning with the SFY ending June 30, 2010.

Response: As described in our Response to CMS's Recommendation for Finding #4 above, the State requests technical assistance from CMS concerning how the State must calculate the non-risk UPL for each MHP and the appropriate federal statutes, regulations and/or other federal guidelines that should be used related to making this calculation. This could significantly influence how the State will amend its State Plan to comprehensively describe the reimbursement and cost-determination methodologies for mental health services and the actual providers of service (e.g. hospitals, counties, other non-state governmental entities, and other private operated facilities, etc.). The State may consider CMS's suggestion to complete SPA #09-004 to specify that specialty mental health services providers be reimbursed up to actual (e.g. "fair and reasonable") cost according to appropriate federal guidelines. Further limitations in reimbursement for some/all

categories of providers could then be included in the Medi-Cal Specialty Mental Health Services (SMHS) waiver or associated authorities. However, in order to make this determination, the State needs a fuller understanding of the specific federal statutory/regulatory authorities related to: (1) the categories of providers that must be established or the State's flexibility in establishing provider categories; and (2) the specific federal guidelines for establishing appropriate reimbursement and cost determination methodologies which will impact how the state calculates the non-risk UPL for each MHP.